6-000 Quality Assurance/Improvement (QA/QI)

6-001 Overall Quality Framework: 482 NAC 6-000 sets forth the requirements of the NHC's Quality Assurance/Quality Improvement Program. 482 NAC 6-000 also establishes the Department's expectation for the medical/surgical and MH/SA plans to work collaboratively with the Department in effectively managing and monitoring the quality of care provided to clients, through a continuous QA/QI Program. In addition to developing and implementing the NHC program according to policy and procedures already discussed in this Title, the medical/surgical and MH/SA plan shall follow QA/QI methodologies, participate in all aspects of the QA/QI activities and comply with all performance and accountability measures, as outlined in this Chapter and in the contract between the Department and the medical/surgical and MH/SA plan.

The Department requires the medical/surgical and MH/SA plan to develop and implement, under the Department's oversight and monitoring, a continuous Quality Assurance/Quality Improvement (QA/QI) Program, that meets the following guidelines:

1. Is consistent with the Department's QA/QI program, provision of Medicaid-covered services, and utilization review requirements;
2. Provides for review by appropriate health professionals of the process followed in delivering health services;
3. Provides for the complete and timely collection of data sufficient for the accurate measurement of health plan performance and quality patient care;
4. Provides for the regular and ongoing collection, analysis, interpretation and reporting of the NHC data; and
5. Provides for making necessary changes through corrective action plans.

Each medical/surgical and MH/SA plan shall make all its QA/QI records, including its findings and data, where applicable, available to the Department. While the Department considers all information provided by the medical/surgical and MH/SA plan are subject to the Nebraska Public Records Act, the Department shall only provide information regarding the NHC in the aggregate.

The Department, its contracted entities or designees, or the Centers for Medicare and Medicaid Services (CMS) officials, may evaluate, through inspection or other means, the quality, appropriateness and timeliness of services performed under the NHC. The medical/surgical and MH/SA plan shall maintain an appropriate record system for services to NHC clients.

6-002 Continuous Quality Assurance/Quality Improvement Program: The Department requires the medical/surgical and MH/SA plan to establish an internal, continuous QA/QI program that provides a mechanism for the plan to monitor, evaluate and take action to improve the quality of care. The medical/surgical and MH/SA plan is required to develop and implement QA/QI activities based on standards defined in the Department's Quality Assurance Plan (QAP), pursuant to 1932(c)(1) of the Social Security Act, and as specified in the contract between the Department and the medical/surgical and MH/SA plan. The Department's QAP is based on the QA guidelines developed by the Centers for Medicare and Medicaid Services (CMS) as part of its Quality Assurance Reform Initiative (QARI) (see 482-000-27, Quality Assurance Plan), Health Care Quality Improvement System (HCQIS) and Quality Improvement System for Managed Care (QISMC).

The National Association for Healthcare Quality defines QA/QI as a process where performance is measured against expectations and a corrective action is taken. Quality improvement is defined as a means of raising quality performance to unprecedented levels. The overall success of the NHC is measured by physician participation, client awareness, focus on prevention and outcome measurements. Quality means meeting or exceeding the client's expectations of services. The NHC strives to provide greater access to services, improve the quality of clinical outcomes and assure appropriate utilization of services.

The Department and the medical/surgical and MH/SA plan shall work cooperatively to develop and implement an effective QA/QI Program within the parameters of 482 NAC 6-000.

6-002.01 Purpose: The purpose of the NHC's QA/QI program is to continuously improve the quality of care and services provided to all clients enrolled in the NHC and to identify and act upon opportunities for improvement. The NHC shall promote the delivery of health care and services in accordance with established benchmarks and performance goals and measure performance against the benchmarks in order to improve performance.

6-002.02 Goals: The goals of the NHC's QA/QI program are to:

1. Provide a mechanism by which the quality of clinical care can be assessed, monitored, evaluated and improved;
2. Provide a mechanism by which the quality of services can be regularly assessed, monitored, evaluated and improved;
3. Define the authority of the Quality Assurance Committee (QAC) committee and subcommittee(s) and their responsibility to the governing body;
4. Encourage provider and client participation, therefore ensuring that stakeholders are involved in the process; and
5. Promote awareness to issues pertinent to the community's health and well-being.

6-002.03 Objectives: The objectives of the NHC's QA/QI Program are to:

1. Define the population served and identify quality initiatives specific to the population;
2. Utilize information and data on, at a minimum, a quarterly basis to measure the quality of care and services being provided;
3. Establish a provider network knowledgeable of the concepts of continuous QA/QI and able to incorporate them into all aspects of the NHC;
4. Encourage clients to give feedback and provide an accessible mechanism to voice concerns;
5. Promote provider feedback and provide an accessible mechanism for them to voice concerns;
6. Develop relationships with public health and community programs; and
7. Evaluate the effectiveness of the QA/QI program and continue to strive for improvement.

6-002.04 Scope: The scope of the NHC's QA/QI Program will be comprehensive and requires the medical/surgical and MH/SA plans' involvement in all aspects of the NHC. The QAP addresses the quality of clinical care as well as the quality of non-clinical aspects of service, e.g., client participation and enrollment processes, interface with the enrollment broker services, system requirements, implementation activities and timelines, and contract monitoring.

In accordance with the standards established by the National Committee on Quality of Care (NCQA), the QAP shall also focus on the following six functional and/or clinical areas:

1. Quality Improvement;
2. Utilization Management;
3. Credentialling;
4. Member Rights and Responsibilities;
5. Preventive Health Services; and
6. Medical Records.

The QAP allows for an objective and systematic review and evaluation of the quality and appropriateness of all care and services delivered for the NHC. Collection of information and data based on demographic groups, care settings (e.g., inpatient, ambulatory, home care, physician offices) and the type of services provided (e.g., primary care, specialty care, ancillary care, preventative care) is critical to the success of the NHC. Through the use of peer review, trending and data analysis, patterns emerge that can be compared to established standards. This information will be used to take corrective action, establish new benchmarks, demonstrate effectiveness, and/or identify needs.

6-002.04A QA/QI Staff: The QAP developed by the medical/surgical and MH/SA plan shall identify staff who are responsible for the operation and success of the QA/QI program. Such person(s) shall have adequate and appropriate experience and will be accountable for all QA/QI activities of the medical/surgical and MH/SA plan, along with participating in the Department's collaborative QA/QI process.

6-002.05 Quality Assurance Committee: The Department's QAC provides the administrative oversight necessary to perform the QA/QI activities of the QAP. The committee is an inter-disciplinary committee that includes providers, administrative staff, and other stakeholders as deemed appropriate by the Department. The Department shall establish a QAC to meet these requirements. The medical/surgical and MH/SA plan shall incorporate similar administrative infrastructure into their program, to include a QAC, Board of Directors, Medical Director and QA/QI Management Staff.

The QAC, within the Department, shall have the following responsibilities:

1. Identify priorities specific to the health, well-being and services provided to the NHC clients;
2. Determine indicators by which the quality of care and service can be monitored;
3. Review data and information designed to monitor and evaluate the quality and appropriateness of the care and services provided on, at a minimum, a quarterly basis;
4. Recommend actions to improve the quality of care and services;
5. Annually review the effectiveness of the QAP, and make recommendations for changes, if appropriate; and
6. Submit quarterly reports, at a minimum, to the Department and the medical/surgical and MH/SA plan that summarize the QA/QI activities of the NHC, including any recommendations.

6-002.06 Quality Assurance Subcommittees: The Department shall focus on the following activities, in the form of subcommittees (consisting of providers, administrative staff and other persons deemed appropriate by the committee/Department), and reporting and related activities, to evaluate the effectiveness of the NHC. The Department will utilize the most recent HEDIS criteria, other continuous QA/QI specifications, to measure compliance in all of the following areas; and provide oversight and monitor the plan:

1. Utilization Management;
2. Credentialling;
3. Network Development;
4. Provider Performance;
5. Member Advocacy and Education;
6. Preventative Health; and
7. Medical Records.

6-002.07 Provider Participation: Participating providers are informed about the NHC's QA/QI Program through the following activities:

1. Initial contracting process with the plans;
2. Provider handbooks, newsletters and other information-sharing activities produced by the plans;
3. Provider meetings conducted by the Department and the medical/surgical and MH/SA plan;
4. Provider focus groups conducted by the Department; and
5. Provider newsletters and notifications Issued by the Department.

Providers are encouraged to participate in the NHC by becoming network providers in the NHC and/or becoming members of the various focus groups, subcommittees or QAC.

Participating providers shall allow the plan and Department access to medical records and facilities for purposes of performing QA/QI activities.

6-002.08 Data and Information Sources: The Department shall utilize, but is not limited to, the following sources to identify opportunities for improvement:

1. Medical records;
2. Member complaints/grievances;
3. Satisfaction surveys;
4. Utilization management data;
5. Claims processing activities;
6. External audit reports;
7. Client service reports;
8. Encounter data (HMO or Prepaid Health Plan only);
9. Enrollment; and
10. Plan-submitted quarterly reports.

The medical/surgical and MH/SA plan shall have methods to verify whether services reimbursed by Medicaid were actually furnished to clients by providers of the plan and subcontractors.

6-002.09 Review Process: A potential quality of care concern will be forwarded to the Department's QA/QI Manager, and to the medical/surgical and MH/SA plan's QA/QI Department. Additional information will be gathered by the Department and/or the medical/surgical and MH/SA plan, as appropriate. The concern will be shared with the Department's and/or the medical/surgical and MH/SA plans' QAC. If necessary, a physician of like specialty will be asked to review the case and submit any comments or recommendations in writing. The QACs of the Department and medical/surgical and MH/SA plan shall review the concern and make any final recommendations.

6-002.10 Levels of Concern: Quality of care or service concerns identified through the QA /QI process will be categorized for assessment, intervention, resolution and reporting as follows:

1. Serious: The problem resulted in, or contributed to, the death of a patient or seriously jeopardized the health of a patient (though the eventual outcome may have been satisfactory). Immediate intervention by the Medical Director of the medical/surgical and MH/SA plan and the Department is required at the provider and the entity level.
2. Substantial: The problem involved a significant deviation from the Community/National standards of care with respect to diagnosis, treatment, or expected outcome; direct intervention by the Medical Director of the medical/surgical and MH/SA plan and the Department at the provider and entity level is required.
3. Minor: The problem had a minimal or inconsequential effect on the health status of the member; intervention not required, continue to monitor to identify trends; direct intervention at the provider level not required.
4. Service: The problem involves the healthcare delivery system and did not directly impact the medical intervention required for health of the client but did impact the client's satisfaction. Ongoing monitoring to identify trends required.

6-002.11 Corrective Action: When the QAC of the Department determines that inappropriate care or substandard services have been provided, or services which should have been furnished have not been provided, the QAC is responsible for communicating concerns identified and outlining the corrective action necessary. The Medical Director of the Department is responsible for working with the medical/surgical and MH/SA plan and provider to develop and implement a corrective action plan, if appropriate. The QAC is responsible for communicating a summary of the case, findings and corrective action recommended to the Department's contract manager for any additional action.

The QAC may recommend and initiate the following actions:

1. Letter of information;
2. Letter of censure, requested plan/provider response;
3. Site visit, with correction action plan required;
4. 100% review of all cases;
5. Second opinion for all surgical cases;
6. Plan/provider be closed to new members;
7. Suspension;
8. Termination; and/or
9. Other.

6-003 Quality Improvement Process: As a means of measuring quality, and in conjunction with Preventative Health, the Department shall conduct focused studies. The Department utilizes participation from the Department, the plan, providers, clients, and other entities with expertise in the above areas to form subcommittees of the Department's QAC to develop standards for evaluating quality improvement and quality of care in the NHC.

6-003.01 Medical/Surgical Specific: The Department may require the medical/surgical plan to pursue continuous quality improvement in selected areas, such as -

1. Health Services for School Age Children/Immunization;
2. Mammography;
3. Cervical Screenings;
4. Pediatric Asthma;
5. Diabetes (see 482-000-28, Nebraska Diabetes Consensus Guidelines);
6. Prenatal Care;
7. HEALTH CHECK (EPSDT);
8. Disabilities;
9. STD, specifically Chlamydia;
10. HIV/AIDS;
11. Elevated Blood Lead Levels;
12. Tuberculosis;
13. MH/SA; and
14. Additional items as determined by the Department.

6-004 Plan Review: The Department is responsible for monitoring the QA/QI activities of the medical/surgical and MH/SA plan, and facilitating any necessary corrective action that should be taken by the medical/surgical and MH/SA plan, as appropriate. The Department shall monitor the medical/surgical and MH/SA plan's adherence to internal QAP standards through the following mechanisms:

1. External Quality Review - The Department shall monitor the quality of care provided by the medical/surgical and MH/SA plan through an annual, independent, external review. The Department contracts with a Peer Review Organization (PRO);
2. Periodic Medical Audits - The Department shall conduct periodic medical audits to ensure that the medical/surgical and MH/SA plan furnishes or its contracted entity quality and accessible health care to enrolled clients. These audits are conducted at least annually and must identify and collect management data;
3. Contract Monitoring - The Department shall monitor contract compliance, ensure state and federal requirements are met and that the NHC meets its intended goals and objectives; and
4. Other methods as deemed appropriate by the Department and agreed upon with the medical/surgical and MH/SA plan.

Through these methods, the Department shall work with the medical/surgical and MH/SA plan to achieve compliance with the Department's QAP standards and develop a corrective action plan for any identified deficiencies in delivering services. The Department shall monitor the plan to ensure that the corrective plans are implemented and effective. The plan is required to cooperate with the federally mandated and the Department's designated External Quality Review Organization (EQRO).

6-004.01 Review Activities: Through the use of external and internal review activities, the Department may focus on selected areas, such as:

1. Medical Record Review, but not limited to:
   a. Organization of Medical Record;
   b. Patient Information;
   c. Content of Medical Records;
   d. Continuity of Care; and
   e. Health Promotion.
2. Quality Management and Improvement, to include:
   a. Program Structure;
   b. Program Operation;
   c. Health Services Contracting;
   d. Continuous Quality Improvement;
   e. Member Satisfaction;
   f. Health Management Systems;
   g. Clinical Practice Guidelines;
   h. Quality Management/Quality Improvement Studies/Assessments;
   i. Effectiveness of the Quality Improvement Program; and
   j. Delegation of Quality Improvement Activity.
3. Utilization Management, but not limited to:
   a. Policies and Procedures;
   b. Utilization Management Procedures; and
   c. Utilization Management Documentation.

4. Credentialling and Recredentialling, but not limited to:
   a. Policies and Procedures;
   b. Credentialling Documents; and
   c. Recredentialling Documents.
5. Member Rights and Responsibilities, but not limited to:
   a. Policies and Procedures;
   b. Member Responsibilities;
   c. Plan Responsibilities; and
   d. Confidentiality.
6. Disease Prevention and Health Promotion Services, but not limited to:
   a. Disease Prevention and Health Promotion Services; and
   b. Participation with Public Health Agency initiatives; Participation with, disease reporting requirements, and preventative health programs.

6-005 Accreditation: The medical/surgical (HMO only) and the MH/SA plan is required to meet all NCQA (National Committee for Quality Assurance) requirements for accreditation, and to meet any subsequently federally mandated national standards, as a managed care organization. The NCQA areas that will be monitored by the Department are:

1. Administrative Policies and Procedures;
2. Advertising and Marketing for Managed Care Organizations;
3. Utilization Management;
4. Credentialling and Recredentialling;
5. Members' Rights and Responsibilities;
6. Preventive Health Services; and
7. Medical Records.

The Department shall utilize contract deliverables to document the medical/surgical (HMO only) and MH/SA plan's compliance with NCQA standards.

The medical/surgical plan (i.e., PCCM network) will utilize the NCQA standards as benchmarks for care, where appropriate.

6-006 Submission and Use of Encounter Data: The Department requires the medical/surgical (HMO only) and MH/SA plans to submit encounter data, per Departmental specifications, and to participate in all encounter data review and technical-readiness assessments (see 482-000-28, Encounter Data Procedure Guide).

The medical/surgical (HMO only) and MH/SA plans are required to submit all data reflecting all services provided to the NHC clients, contracted or delegated. The same plans shall have processes in place to ensure that all data submitted to the Department reflects all services rendered within the last ninety days. The Department shall impose contractual penalties for the non-submission, incomplete or late submission of encounter data.

Encounter data submissions shall:

1. Be submitted on a monthly basis;
2. Include all services; and
3. Be used to evaluate the medical/surgical (HMO only) and MH/SA plan performance and overall effectiveness of the NHC.

The most recent HEDIS criteria and other continuous QA/QI specifications are the tools for quality measurement that are utilized by the Department. The most recent HEDIS criteria will be reported by the medical/surgical (HMO only) and MH/SA plans through the submission of encounter data. Data analysis, trending and comparative studies with national and program-specific standards will allow the Department to establish benchmarks and QA/QI activities for the NHC.

The Department shall utilize encounter data, programmatic and contract deliverables, and results from the various oversight/monitoring activities identified in 482 NAC 6-004 to evaluate the following, but not limited to, NHC underlying principles:

1. Improved health, wellness and quality of care;
2. Cost-effective quality health services;
3. Increased access to primary care;
4. Expanded choices;
5. Greater coordination and continuity of care; and
6. Better health outcomes through effective care management.

6-006.01 Reporting: Through the use of encounter data and other contract deliverables, the Department shall focus on, but not limited to, the reporting areas:

1. Expenditures/Usage;
2. Eligibility;
3. Utilization;
4. Quality;
5. Provider Access; and
6. Provider expenditures.

6-006.02 Performance Measures: In addition to developing and implementing the NHC program according to policy and procedures already discussed in this Chapter, the medical/surgical and MH/SA plan shall follow QA/QI methodologies discussed in this Chapter and adhere to all specified requirements of the contract.

6-007 Data Requirement for PCCMs Only: The most recent HEDIS-like measures, as developed by the Department and the Department's Data Manager will be utilized through the claims data maintained by the Department. The Department will calculate HEDIS-like data for the PCCM Network from which the PCCM Administration will focus their QA/QI activities.

The Department shall utilize encounter data, programmatic and contract deliverables, and results from the various oversight/monitoring activities identified in 482 NAC 6-004 to evaluate the following, but not limited to, NHC underlying principles:

1. Improved health, wellness and quality of care;
2. Cost-effective quality health services;
3. Increased access to primary care;
4. Expanded choices;
5. Greater coordination and continuity of care; and
6. Better health outcomes through effective care management.

6-007.01 Reporting: Through the use of claims data, the Department shall focus on, but not limited to, the reporting areas:

1. Expenditures/Usage;
2. Eligibility;
3. Utilization;
4. Quality;
5. Provider Access; and
6. Provider expenditures.

See 482-000-29, Claims Data Format Requirements and Referral Management and Prior Authorization - PCCM Only.